

# The Times and Register.

VOL. XXXVI. No. 10. PHILADELPHIA AND BOSTON, NOV. 26, 1898. WHOLE No. 974.

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## ELECTRICITY IN MODERN SURGERY.

ADDRESS BY DR. C. R. DICKSON,  
Of Toronto,  
President of Electro-Therapeutic Society.

The following is part of an address delivered by Dr. C. R. Dickson, of Toronto, president of the American Electro-Therapeutic Association, at the recent meeting of the organization in Buffalo, and is of interest as shedding light on a subject which is as yet not thoroughly understood by the general public.

"For many years past the thoughts of those who are interested in the many branches of this wondrous subject, electricity, have turned to this city, and it has been the Mecca of the electric pilgrims. On its outskirts the wildest dreams of the Arabian Nights have been outdone. Science, ever triumphing over nature, has harnessed that most beautiful of all nature's handiwork, and, as though by the subtle touch of the wand of a magician, the very country has been transformed and solitary fields have become veritable hives of human industry, the outcome of the mighty power of Niagara transformed and

transmitted. Massive factories are run on every side where but a few short years ago were found naught but vacant lots. To us, witnessing it for the first time, it is a milestone of progress, illustrating man's ingenuity, the triumph of his brain. Buffalo is truly the electrical city of the age.

"The necessity for the existence of such an association as ours has been questioned not only here, but elsewhere; hence it may be necessary to explain our position. It has been asked, 'Why should there be such an association?' Electricity is only one of many therapeutic agents, and it would be absurd to have a separate association to consider each therapeutic agent. At first glance this may seem a quite rational question. Our colleges teach us how to administer opium and its various derivatives, therefore the necessity for an opium society does not exist; but do our colleges teach us anything about electricity worthy of the subject?

The answer to this question is quite unnecessary in the presence of the members of our association. Anyone should be depended upon to prescribe and administer the ordinary, or even the extraordinary remedies to carry out any regulation form of treatment; but I, for one, should fear to trust myself to the tender mercies of the general practitioner of to-day did he in his wisdom consider it necessary to use this agent, electricity, unless he had paid some special attention to the mastery of it. The contention is an absurdity unworthy of America, the vaunted land of progress, and of Buffalo, the electrical city. In my own benighted land, even, we are more enlightened than that. This is an age of specialism.

"The old-time practitioner, then the physician and surgeon, seems passing away. Surgery is being divided and sub-divided, until at one time we feared that we were to be confronted with an appendix surgeon. Our patients are reaping the benefit of all this. Why then should we call a halt? No! Let onward be our cry. The time is past when a physician, the proud possessor of a solitary magneto-electrical machine turned by a crank, considered his armamentarium electricum quite complete. One has but to glance at our programme to see to what extent electricity may be used, and used to advantage. A programme such as ours should prove a perfect revelation to him who has not kept well up to this progressive age. Could such a programme or one-hundredth part of it be intelligently discussed in any other existing society to-day not dealing distinctly with the subject? No! I greatly fear it would be a hidden book, a stumbling block.

"The hope of the future lies in those who are now thronging wisdom's halls, and it is a subject for congratulation that this association is to be asked to take action, bringing the needs of the hour before the authorities competent to deal with them. The student with mind as yet unwarped by prejudice must be in a position to obtain a comprehensive, intelligent grasp of the whole subject, that he may turn his theo-

ries to practical account in his professional career. But even he, unless endowed by these inestimable blessings, common sense, patience and gentleness, will find his efforts unavailing, and he must be a close observer of nature and her laws, seeking to assist, rather than to combat her. Electricity is an agent most powerful for weal or woe. A great responsibility rests upon our educators, and the sooner they awake from their strange lethargy the better will it be for our reputation as an enlightened, progressive, scientific profession. The commercial world has taken such advantage of the rapid strides of electricity as a science with fixed laws that we have laid ourselves open to the charge of neglect. Let us hasten to make amends for the past and remove some of the reproaches that rest on this, the noblest profession in this fair world.

"Our association was organized some eight years ago, because it was felt that the subject of electro-therapeutics could not be discussed in any existing society in a scientific and practical manner without controversial digressions of no value whatever. It was felt, and felt strongly, that electricity had been left too long to the charlatan, the incompetent and the unscrupulous. It was also felt that we had another foe of hardly less dangerous character—the overzealous.

To combat all these and cultivate and promote knowledge of electricity wherever it can be of service in medicine and surgery is the object of our association. It must be admitted that we are setting about this in the most practical manner possible. In fact, I know of no other association in which more practical or more useful work is being done. To carry out this idea successfully we have associated with us other than purely medical practitioners, and the association has proved a most happy one, and fruitful of nothing but good. Thus the electrical engineer and expert study electricity's laws and note its action upon inert matter. The biologist and physicist go a step farther and study these laws in their action upon liv-

ing tissue, and their labors are turned to practical account by the physician and surgeon. The curative and palliative powers of the agent are whom have access to my clinics.

"The clouds are breaking in our horizon. On my side of that imaginary boundary line we find increasing interest being manifest, and it gives the greatest satisfaction to say that my own warmest friends in the city of my adoption are the men who stand in the front ranks of medicine and surgery, and electro-therapy has a recognized standing, inasmuch as

special departments devoted to it are to be found in our public hospitals. I have had the honor to organize and now to preside over four such departments in as many hospitals, and more intelligent inquiries are being made by the students of the various medical colleges, all of whom have access to my clinics.

"A rock we must avoid is that on which many a stronger society than our own has come to grief, the clique. And the furtherance of personal ambition or personal designs must be shunned."

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#### CLIMATIC AIDS IN THE CURE OF DISEASE.

BY JOSEPH R. CLAUSEN, A. M. M. D.

Climatology as a science is still in its infancy, but sufficient progress has been made to demonstrate beyond doubt the fact that proper climatic conditions form the most potent of all factors in the cure of disease.

To go further than this, even, and to demonstrate in a more marked degree the value of such conditions, the fallacy has been shown of attempting to cure disease where the climatic conditions are favorable to the development of the disease germ. To every true student of the healing science these are accepted facts, and no conscientious physician will dispute them.

Various localities, both in this country and abroad, have laid claim to possessing a climatic environment fatal to the development and propagation of the micro-organisms that are the true causes of disease, and all, to a greater or less extent, are able to substantiate the claim.

Of such localities we may mention Oregon, Colorado, Southern California, some parts of Italy, the South of France and others less frequently

mentioned, but, while all possess, in a great measure, the qualities of climate that are aids, great aids, to the recovery of health, each in turn falls short in some essential point, if in no other, in the fact that while they are beneficial in certain forms or stages of disease, they are equally injurious, if not fatal, in others. For years the leading climatologists of the world have united in searching the world over for a section of the earth's surface where the climatic conditions were suited to every form of physical debility, and where the effect of such conditions would be always beneficial, never reactionary or injurious. As a result of this search the Warm Springs Valley of Virginia has been brought into world-wide repute, surrounded by the pine-clad mountains of northwestern Virginia, at an elevation of 2500 feet above the level of the sea. It is blessed with a climate wholly exempt from moisture, and a temperature ever free from extremes in summer and winter alike. Added to the benefits derived from the conditions of altitude being perfect, the natural drainage equally so, and the

air always dry, the luxuriant growth in and surrounding the valley absorbs the carbon dioxide and gives out oxygen, resulting in an atmosphere highly ozonized, and as ozone is an indispensable aid to the successful treatment of any disease, the very air the patient breathes here is not only invigorating, curative and health-giving, but death-dealing to the micro-organisms that lurk in the system, and that unchecked will, in the end, undermine and destroy it. Aside from climatic conditions that are perfect, nature has contributed from her full store everything else to make the valley an ideal spot for permanent or temporary residence. The scenery is grand, picturesque and impressive, embracing the different ranges of the Allegheny Mountains on the one hand and the far-distant Blue Ridge on the other. The view shows a wild, wooded, virgin country in one direction, and in the other the fertile, cultivated Warm Springs

Valley, with its many evidences of what art can do for the comfort and convenience of mankind. Not least of the latter is the well-built and perfectly-kept roads and drives that lead to the many accessible points from which residents and visitors can drink in the beauty of their surroundings.

The Warm Springs Valley is situated on a branch of the Chesapeake & Ohio Railroad, eight hours' run from the city of Washington, eleven hours from Philadelphia, and about thirteen from New York. From either point the trip is a most pleasant one, as Pullman compartment sleeping cars run through, without change, over a well-balasted roadbed, through a pretty section of country and attended by employes whose courtesy is proverbial. Are you interested in climatology in a general way or for more pungent reasons? Test the claims to your attention set forth by the Warm Springs Valley.





## Society Reports.

### NEW YORK ACADEMY OF MEDICINE—SECTION IN ORTHOPEDIC SURGERY.

Meeting of October 21, 1898.

#### OBSCURER INJURY OF THE HIP.

Dr. G. R. Elliott presented a boy 2 years and 8 months old, who had fallen from a tree two months before. He complained of the left knee, but was able to walk and run. His father reported that the left foot had been dragged with a decided limp and everted to a right angle, and that its normal position had been restored after manual traction and manipulation. A slight limp had, however, persisted. The left leg was 3-8 inch short and the left thigh 1-2 inch atrophied. Gentle manipulation seemed to produce a slight slipping of the joint. The child's ligaments were generally relaxed. He suggested the diagnosis of a dislocated hip reduced at once by manipulation.

Dr. N. M. Shaffer said that the limbs were practically of the same length, and that whatever might have been the lesion there were at this stage no positive signs of hip disease, dislocation or separation of the epiphysis.

Dr. A. B. Judson found the trochanter enough above the line to make it probable that there had been a separation of the epiphysis.

Dr. T. H. Myers said that the limp might be from habit acquired when the hip was painful. The slight shortening in itself would not cause a limp. Irregularity in the length of the limbs had been said to be the rule rather than the exception. The cause of the shortening was not ap-

parent, since a dislocation, when reduced, should not leave any shortening.

Dr. R. H. Sayre had noticed the presence of marked knock-knee, and the father had said that the child had always turned in his toes. In other words, he had been unconsciously walking Indian fashion to make his feet more comfortable and to protect the arch of the foot. Beyond this the child appeared to be well.

Dr. P. J. Fiske thought that there might have been a bending of the femoral neck due to the accident or acquired in some other way.

Dr. Elliott said that the head of the bone was in its socket, wherever it might have been immediately after the accident. He thought that the question of separation of the epiphysis remained undecided. He stated that the child had ridden a bicycle frequently since he was taught by his father to ride when he was 18 months old. His greatest distance had been four miles. The boy was 36 1-2 inches in height and his weight was 31 pounds. His bicycle weighed 11 pounds, diameter of wheel, 13 1-2 inches; crank, 4 inches; wheel base, 21 1-2 inches; gear, 46. He had ridden without trouble since the accident, but the exercise was forbidden when the patient was first seen, a few days ago. His brother, 4 1-2 years of age, began to ride a wheel when 3 years old. He had a record of a 20 mile run, and was in perfect health.

#### THE USE OF THE BICYCLE BY CHILDREN.

Dr. Myers said that in the case of a child who rode a bicycle great care should be used in the adjustment of the height of the seat and the handle-bar.

Dr. Sayre examined the boy's bicycle and said the construction of the seat was such that it would compel the patient to appear before the Section on Genito-Urinary Diseases later on. He did not see why a boy of that age should not ride a wheel if he kept off the street. The exercise should not be more than he could stand. Small children sometimes rode ponies and seemed to get along perfectly well.

Dr. Judson said that young children rode tricycles without attracting any especial attention. The bicycle furnished ischiatic support. In appropriate cases he advised its use when it was desirable to combine speedy and agreeable locomotion with relief of the lower extremities from carrying the weight of the body and from the pressure and concussion incident to walking and running. The same was true of horse-back riding. Aside from the risk of accident, he thought that the moderate use of the bicycle at any age would promote normal development and health.

Dr. R. Whitman thought bicycle riding was a good exercise for knock knees and weak feet.

Dr. H. L. Taylor strongly disapproved of bicycle riding for young children, not from an orthopaedic standpoint, but on the ground of its being injurious to the general health.

Dr. Elliott said that children generally assumed bad attitudes on the wheel, leading to faulty development of the thorax. At an early age the bones were soft and the ligaments undeveloped and unfitted to stand the special requirements of riding a bicycle, and the result might be, as in the case of the patient, a relaxed ligamentous system. Bicycle riding by children tended to disproportionate development of the legs when compared with the arms. It should not take the place of general exercise, which developed the whole body alike.

#### TRAUMATIC SPINE.

Dr. Fiske exhibited a man 34 years of age, who had recovered from injury of the spine with paraplegia and rectal vesical symptoms. The patient had been presented at the meeting of May 21, 1897.\*

There had been no return of the symptoms and the recovery was now, more than four years after the accident, complete. The violence had been extreme, followed by rigidity and pain in the dorso-lumbar region, complete paralysis from the waist down, and incontinence of feces and urine. There had been no crepitus and no deformity. The patient was perfectly helpless. The diagnosis was severe spinal trauma, concussion of the cord, damage to ligamentous structures and probably partial dislocation with spontaneous reduction. Treatment had been by a plaster of paris jacket, worn with occasional renewals, for 10 months. There had been no bed sores. Recovery with control of sphincters had been complete and the man was apparently in perfect health. In answer to questions Dr. Fiske said that ankle clonus had not been present, that the lower part of the abdomen had been sensitive, but the scrotum, penis and sacrum were anesthetic; that the sensory paralysis disappeared first; that there had been considerable atrophy of the muscles of the thigh and calf, probably from disuse; that the patient had felt nothing give way, as he was immediately unconscious, and that he began to use his legs in about four months, and could walk at the end of seven months. The anesthesia of the scrotum and penis had led to the opinion that the injury was at the thirteenth dorsal vertebra and first lumbar.

Dr. Elliott thought that the lesion had not been above the first lumbar. Above that point, which was the end of the cord, there would probably have been destruction of the anterior horn cells with ankle clonus and great localized atrophy. He could hardly conceive of anything less than this happening at a higher level after

\*See "The Medical Times and Register, August 7, 1897, pp. 79, 80.—Editor.

an injury attended with so much paralysis.

Dr. Shaffer had seen several such cases. The lower the point of injury the better would be the prognosis. The result had certainly been very good in this case, where there must have been a partial dislocation or fracture. He recalled the case of a man who was thrown from a vehicle and struck the ground in a sitting position. Rigidity of the spine had developed, but recovery had followed with perfect motion of the spine. A certain amount of compression of the anterior column could occur without serious results. If the posterior columns were injured we would get symptoms such as had been present in the patient exhibited.

Dr. Sayre had seen a case similar to the one under consideration. In a railroad accident in which an express car had rolled down a bank a man had been struck violently by the safe. He was paralyzed from the waist down, with no control of the rectum or bladder. This condition lasted some three years. He gradually improved under treatment similar to that described, and had been restored to perfect health.

#### FRACTURE OF THE SPINE.

Dr. Whitman presented a patient with a rather different history. He was a young man, 22 years of age, who had fallen 25 feet from a cliff. He could walk with assistance and, although he had pain, stiffness and weakness in the back, numbness and weakness in the legs and pain in the lower part of the abdomen and the anterior surface of the thighs, he resumed work as a clerk at the end of a week. Dr. Whitman had examined him on August 8, about two weeks after the accident, on account of a "lump," composed of the projecting spines of the second, third and fourth lumbar vertebrae. There was some pain on extensive motion of the back and moderate rigidity at the seat of the fracture. A brace relieved the symptoms in a great degree, and at the end of a month he considered himself well, although he was still wearing the brace. It was seen that the normal lumbar lordosis had been

replaced by a projection. Motion was practically normal. There had been a fracture and compression of the vertebral bodies and yet the symptoms had been insignificant.

Dr. Myers recalled the case of a man who had fractured his spine in a fall of 25 feet in a doubled forward position. Pain was not severe, but weakness in the lumbar region, the seat of the fracture, prevented sitting up or standing. He was in bed for three weeks, and then walked with a cane. A kyphos was found and a spinal brace relieved his symptoms very quickly. He was well in six months. Fractures of the vertebrae often gave symptoms but poorly marked when compared with fractures in other locations. The most common symptom was weakness. Crepitus and false points of motion were not usually detected. Pain was moderate and deformity was frequently absent until after the patient had assumed the erect position for several days.

#### UNUSUAL FRACTURES OF THE NECK OF THE FEMUR.

Dr. Taylor presented a boy 15 years of age, who in October, 1896, felt sudden severe pain in the right leg, followed by lameness for two weeks. No shortening was noticed. After that he had lameness and disability with but little pain till January 3, 1897, when he slipped and fell on the floor with the knee bent under him. He was unable to rise or walk, and the neck of the right femur was found to be broken. He was treated by a plaster of paris application, and in July, 1897, when first seen by Dr. Taylor, he was limping badly; the trochanter was one inch above the line, there was extreme eversion and very limited motion. Crutches were advised. In December, 1897, the patient had been free from pain for many months, and there was increased motion. In April, 1898, under an anesthetic, more mobility and lessened eversion were gained by manipulation, which was repeated in September, 1898, with further improvement.

Status praesens: 30 degrees of free lateral motion, considerable free rotation and 30 degrees of flexion.

Trochanter a full inch above the line. Walking was very free, but with a slight limp. An apparatus, soon to be laid aside, was worn to prevent outward rotation.

Dr. Taylor also presented a boy of 18 years, who, in December, 1897, fell on his left knee. There was immediate stinging pain in the left hip, but he could walk with some assistance. He soon walked with a cane, and three weeks after the fall there was a marked limp with very little motion in the hip. The limb was one inch short and rotated outward. The trochanter was one inch above the line and there were tenderness, induration and muscular spasm about the hip. Treatment was by traction splint, long crutches and a high sole on the foot of the well side. In May, 1898, the patient had been free from pain for two or three months, and there was more motion. The splint was removed. In September a cane was substituted for the crutches. Status praesens: Walking with a considerable limp. No pain. Can raise the leg while lying. Shortening of one and one-half inches. Limited motion at the hip and adduction. These cases were of especial interest on account of the youth of the patients and the slight violence of the accidents.

Dr. Whitman said that the first patient doubtless had coxa vara, which weakened the neck of the femur, causing it to break under a moderate degree of violence. In three cases of coxa vara in young subjects he had operated by removing a wedge from the base of the trochanter in order to restore the neck to its normal position and strength. The second patient also probably belonged to the same class. He recalled the case of a young colored girl, who, after a period of slight limping and outward rotation, with slight stiffness of the hip and pain in the thigh, suffered a fall on her way to school. She was carried home with typical fracture of the neck of the femur. She was treated by the use of a traction splint with a favorable result.

Dr. Taylor said that he was confirmed in his opinion that bending of the neck of the femur had preceded

ed the accident and had made easy the fracture of the bone in the case of the first patient presented. In the second case, however, there had been no previous signs or symptoms of deformity of the femoral neck, and such a condition must be considered hypothetical.

#### CONGENITAL DISLOCATION OF THE HIP.

Dr. Elliott exhibited a further dissection of the specimen shown at the last meeting of the section.\*

The patient had been a girl 7 years of age. The dislocation of the right hip had been upward and forward. The neck had been found to be short, and the muscles shortened and somewhat atrophied. During life there had been more than one inch of shortening and the child had walked with difficulty, like one with weak muscles. The head had made a deep and extremely well-defined acetabulum, lined with cartilage, below and near the anterior superior iliac spine. The original acetabulum was almost equally well defined, measuring one and one-eighth inches in its vertical and one inch in its transverse diameter, with a depth of one-quarter inch. So well defined a first acetabulum at this age was rare. Lorenz cited one at the age of 18 years, and the older anatomists found them at very late periods of life. As a rule, however, the acetabulum not in use failed to keep pace with the development of the other parts and at an age much younger than that of the specimen it was usual to find it rudimentary and frequently presenting a convex contour. The old acetabulum was found to contain some fat, but was chiefly occupied by an exceptionally large ligamentum teres, measuring one and one-half inches in length, three-quarters inch in width and three-sixteenths inch in thickness, running from a well-defined cotyloid notch through the vertical diameter of the acetabulum to an insertion in the femoral head. As a rule the ligamentum teres had been found at the age of 3 or 4 years to be a mere ribbon or to have disappeared. In the

\*See "The Medical Times and Register," September 24, 1898, p. 179.—Editor.



usual dislocation on the dorsum iliac the disappearance of the ligament might be explained by the facts that it had no function and was compressed closely between the margin of the acetabulum and the femur. In the specimen, however, the displacement had been directly upward, and the tremendous size of the ligament was apparently the result of its being called on to sustain the weight of the trunk at every step in walking. Its great size, then was physiological rather than pathological.

Dr. Whitman said that the old acetabulum appeared to be of fair size, and that, as the tissues were doubtless far more yielding in life than in the preserved specimen, an operation by the open method, in which the hypertrophied ligament would have been removed, might have been successful.

Dr. Sayre said that, as the head was as broad as, if not broader than, the place where the acetabulum should be, it was doubtful whether chiseling away a part of the head would not have been required before reduction.

Dr. Judson presented a photograph of talipes valgus of the left foot in a man about 35 years of age affected with locomotor ataxia of several years' duration. It was an instance of Charcot's joint affecting the tarsus. The patient's right knee joint had been excised for this condition, but stability had not been restored to the knee by the operation. Pathologically there were pulpy and fluid degeneration of the bony and other tissues and disintegration



TABETIC TALIPES VALGUS.

of the structures of the joints. Equino-varus also occurred in locomotor ataxia and in Friedreich's disease, but was the result not of bony changes but of abnormal muscular action. The primary disease was so serious and disabling that the question of treating these secondary affections was not often a practical one. Mechanical treatment might, however, be considered with three objects in view: first, to give firmness to the foot and ankle and direct the sole to the ground; second, to give lateral support to a Charcot's knee and third, to stiffen the knees by the use of automatic joints in order to prolong the period when locomotion is possible with the aid of crutches.



## Editorial

THE TIMES AND REGISTER is published Bi-weekly—Twenty-four issues a year.

All communications, reviews, etc., intended for the editor should be addressed to 367 ADAMS STREET, BOSTON, MASS.

THE TIMES AND REGISTER is published by The Medical Publishing Co., 717 Betz Building, Philadelphia, Pa., to whom all remittances should be made by bank check, or postal, or express money order.

Subscription price is \$2.00 a year in advance. Foreign countries, \$2.50. Single copies, 10 cents.

Advertising Rates may be had on application at the Philadelphia office.

Original articles of practical utility and length are invited from the profession. Accepted manuscripts, will be paid for by a year's subscription to this journal and fifty extra copies of the issue in which such appears.

Reprints of Original Articles are not furnished except on payment of cost price by the author.

Entered at the Philadelphia Postoffice as second-class mail matter.

### CUT RATES AT CORNELL.

The past three years have been unusually eventful in matters medical in New York.

The New York Herald alleges that the medical colleges have commenced to "cut rates," under the following note:

"According to the report of Chancellor Henry M. MacCracken, read at the sixty-eighth annual meeting of the council of the New York University yesterday, there was a general deficit for the year of about \$10,000 in various branches of the institution, due to interest charges upon real estate. Gifts in money, however, have been received during the year aggregating \$346,055, and many very valuable collections of books, models and specimens for the museum have also been contributed. There is a total enrollment of 1625 students, a gain of 22 per cent. since last year. The Chancellor made the following statement, which is taken to be an attack on Cornell University:

"Our medical work, which at the date of the Chancellor's report last year was in an unsatisfactory condition, is now very prosperous. The enrollment of students is more than one-half larger than last year. The faculty is most harmonious and efficient. A few unwilling professors have been spared to join an eager sister university. We regret that the eagerness of this out-of-town corporation to collect hastily a medical school has led them to offer to matriculants of one year ago doctors' diplomas after two years' additional study.

#### COULD NOT MEET CUT IN RATES.

"We could not meet this offer, having announced that the class of 1899 should be our last three years' class. We preferred to lose a score or two of students from our second year class rather than meet this cut in rates. The present indications are

that we shall be the gainers, even as regards the number of students, by our adherence to our high standard."

In another part of his report the Chancellor declared against co-education in medical schools as wholly unsuited to metropolitan conditions. He announced the consolidation with the Bellevue College as "organic and complete." A memorial resolution on the Rev. Dr. John Hall was adopted.

The University Medical College sprung from the ashes and pressed on to a leading institution of learning under the "cut rate" scheme, and now it appears that its faculty, which went bodily out and organized Cornell Medical College, have found it desirable and necessary to resort to the same tactics, not by cutting fees, but by lopping off a year of study.

Chancellor McCracken would do well to explain on what principle of equity or justice his corporation secured the medical college buildings, the property of the University Medical College, without compensating the lawful owners. What "organic" consolidation can be referred to? The University faculty organized Cornell Medical and "combined" with nothing. The faculty of Bellevue simply stepped into their places.

Now, where does the so-called "combine" come in?

Cornell is about to construct another large medical college on a vast endowment, under the shadow of old Bellevue Hospital.

Cornell opens its career under most auspicious circumstances, with a very large endowment and a corps of teachers of international reputation.

However, from past experience and the manner in which successful teaching is best advanced in other places, we believe a mistake has been made in selecting a site so far downtown, and in not making provision for hospital facilities of their own. In the hospital reorganization in New York three years ago all the hospital appointments were controlled by the three medical colleges, but so loud and urgent were the protests of the profession against this monopoly that that arrangement had to be revoked and the nominating power taken entirely out of the hands of the medical colleges. Physicians and Surgeons' Medical College is quite independent of city hospitals. The University and Cornell must soon make similar provisions, else reciprocal under-cutting of rates may be certainly looked for.

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#### A GOOD WORD FOR THE NEW YORK CLINICAL SCHOOL OF MEDICINE.

We have had the pleasure of visiting several of the post-graduate colleges of this country recently and were impressed with the value of the instruction given. We wish at this time to specially speak of the New York School of Clinical Medicine. This school is conducted on the plan of the European institutions for post-graduate instruction and a course at the school is next to a course abroad, with the advantage of the instruction being in English.

The faculty is composed of men of international reputation, who are all able clinical instructors. Each

professor takes only a limited number of students in his class at a time and never more than can receive personal instruction and do actual work. The students at this school do not attend didactic lectures, any physician can get plenty of these in his literature, but the time is devoted to the practical work. Students have abundant opportunity to do all kinds of work under the guidance of the professors.

The school has an abundance of clinical material to demonstrate the teachings of the professors. Many of the professors have recently been

in Europe and present the latest ideas not only of this country, but of the world. The student learns the actual use of all instruments in the various departments.

The operative work on the cadaver is a valuable feature in the courses at this school. All the operations of general and special surgery, intubation, etc., are performed by the students on the cadaver, the eye and the ear operative courses being especially fine.

The school is in a flourishing condition, because it gives just the kind of a course desired by the practical physician. Those who have taken one course feel that they want to return again and take more post-graduate work in the future.

—The Wisconsin Medical Recorder.

We are much gratified to read the above from our well-known Western contemporary, as several of the best known on the staff of this institution are regular contributors to the columns of the "Times and Register."

Their system of teaching is what particularly commends itself; the suppression of long-winded dissertations and the substitution thereof of immediate and personal instruction is to be particularly commended for veterans who have done their time on the benches.

Besides, New York, as a populous centre, provides the anatomical material so essential to all substantial advance in surgery or the specialties.

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#### DIET IN DIABETES.

Treupel (Munch. med. Woch., July 26, 1898) discusses some points in diet. In diabetes the objects are (a) to lessen the production of sugar, and (b) to promote the consumption of sugar already present in the fluids of the body. Both these objects are effected by limiting the carbohydrates. Thus a strict diet of albumens and fat should be imposed, but for not longer than four weeks. Then an amount of carbohydrates may be allowed according to the case. Beer should as far as possible be avoided. Pentose and ramnose belong to carbohydrates, which are well borne without increasing the amount of the sugar. Individualization must always be practiced in the treatment of diabetes. The author then details (a) strict and (b) more generous diets for diabetics. As regards subcutaneous feeding, fat is best adapted for it. After the injection of sugar painful infiltration is often observed, even when sterilized solutions are used. Albuminous solutions are not to be recommended.

Artificial food stuffs are useful in cases of blood diseases accompanied by wasting, in the febrile, and especially in tuberculosis, where the ordinary food stuffs cannot be employed. Artificially prepared fats are comparatively little used, but lipanin and some others are readily absorbed. The ordinary fats, as in butter, cream, yolk of egg, are, however, very digestible. Many artificial preparations of carbohydrates are in use. In infants' foods diastase has converted the starch into sugar. It must be remembered that milk, sugar and other forms (especially honey) contain valuable and soluble carbohydrates, and have the advantage of being cheap. Of all artificial foods the albuminous are the most important. Somatose, nutrose, eucasin, sanotogen and sanose are excellent preparations. The two essentials of these albuminous foods are that they should be palatable and cheap. As yet an ideal preparation—that is, one which will satisfy these two conditions—has not been discovered.



## Book Reviews.

**The History of Prostitution: Its Extent, Causes and Effects Throughout the World.** By William W. Sanger, M. D., New York. Published by the Medical Publishing Company, No. 17 Ann street, New York city. Price, \$2.

With the broad spirit of humanity and a desire to benefit his fellow-man, Dr. Sanger has given to the world, in this book on prostitution, a gem of historic facts. His position of resident physician on Blackwell's Island gives him peculiar advantages of studying prostitution in all its aspects, and he certainly has produced a work of excellent worth. Beginning with the Jews, he follows along the early periods of ancient chronological history to the Christian era. He then takes up the subject with European countries in the middle ages, and details on the methods, laws and customs of those times. Then he continues with the subject in the Asiatic and European empires of modern times, and finally with a complete resume of its history in the countries of the Western Hemisphere. He deals with its diseases, effects on constitutions and moral side; the statistics of its existence in New York city, and the legal aspects, with the attempts at restriction and remedial measures.

While the subject is a most delicate one to handle properly, we are forced to grant that Dr. Sanger has set the matter in a judicious light, and the work is both interesting and instructive, and worthy of great success.

**MANUAL OF ORTHOPEDIC SURGERY.**—By Stewart LeRoy McCurdy, A. M., M. D. Now Ready.

Contains 350 pages of reading matter and 175 illustrations—many of them original half tones.

This book is a condensation of the subjects which belong to the specialty of Orthopedic Surgery. Especial attention is paid to diagnosis and treatment.

Cuts illustrating various stages of a disease are grouped so that comparison may be made more satisfactorily. Price, \$1.25, (net). Address, Room 315 Horne Building, Pittsburg, Pa.

**LATE LITERARY NEWS.**—Much interest has been excited in America by the telegraphic accounts of Hoolley's apparently wholesale purchase of British noblemen for use as decoy ducks to his various stock schemes; and his connection with the highest political officials of the Empire. THERON C. CRAWFORD, who has been in England for **THE COSMOPOLITAN**, takes up the subject in the November issue of that magazine, and under the title of "Hoolley and His Guinea-Pigs," gives a connected story of the derivation of Hoolley and his rise to the control of millions through unlimited cheek and the opportune willingness of distinguished British aristocrats to lend their names for a financial consideration to any sort of a shady transaction.

## CLINICAL SURGERY AND SURGICAL PATHOLOGY

In charge of T. H. MANLEY, M. D., New York

### THE CORSET: A USEFUL GARMENT.

The inevitable corset has been the subject of so much abuse, both deserved and exaggerated, that to see it mentioned in other than disparaging terms is a decided relief. The claims of distorting and even painful effects of its use have been so magnified that few have had the courage to advocate whatever redeeming qualities it might possess. The controversy has aimed to eliminate the abuses by abolishing the corset in toto rather than by seeking to improve it. The result is striking. Makers have increased and wearers multiplied. That the mandates of fashion supply devotees we must admit, but it is also a fact that fashion itself depends fundamentally upon physiological principles. The principles underlying the corset are constantly applied in the prophylactic and curative measures of medical practice so that benefit must inevitably follow its proper use. In commenting upon the vertical and unnatural attitude of man, Doctor T. H. Manley, in the Virginia Medical Semi-Monthly, makes this plain statement: "It has long been my conviction that there is no garment in the female apparel more necessary and comfortable than a properly adjusted corset. \* \* \* Along with imparting grace and symmetry to the figure, it likewise is a support and protection. \* \* \* It takes the superincumbent off the mid-dorsal spine and conveys it to the broad, strong cresta ilii, and also imparts a sense of comfort and security." To meet his requirements of an ideal corset it must be light in weight, strong and durable, so constructed as to be easily cleaned and so adjusted as to support the upper dorsal spine and related parts from the broad

iliac crests. Tight lacing may be harmful, but the assumption that this is synonymous with corset wearing is groundless and yet responsible for the denunciations it has innocently received. It is evident that in dress as in other sanitary affairs much more may be accomplished by judicious advice than by wholesale condemnation.

—The Physician and Surgeon.

### A STUDY OF TWO HUNDRED CONSECUTIVE OPERATIONS FOR THE RADICAL CURE OF HERNIA.

By ARTHUR E. BARKER, F. R. C. S.,

Professor of the Principles and Practice of Surgery and Professor of Clinical Surgery at University College, and Surgeon to University College Hospital.

(Abstract.)

In a paper which I had the honor to read before the Royal Medical and Chirurgical Society in April, 1890, I analyzed my first 50 cases of radical cure of hernia, and I venture to think that a brief study of a further 150 since consecutively operated on may have a certain value.

In the paper referred to three questions were taken as the basis of the inquiry upon which I hoped the 50 consecutive cases would furnish evidence:

1. Is the operation called for?
2. Is it safe (a) as regards the patient's life; (b) as regards the contents of the scrotum?
3. Does it secure against a return of the hernia?

In order to preserve a certain uniformity between the analysis of the succeeding 150 cases, these questions will be still taken as the text of the following inquiry, which in other respects as well will be made to follow

the lines of the first communication as nearly as possible.

The first question now hardly needs an answer, if the operative interference be limited to the young after infancy, and to those who are debarred from this or that calling by reason of the hernia. So far most surgeons are agreed, and in all the cases before me there was good reason for the measure. In many other cases the operation was refused, because there seemed to be very little special reason for its performance. In many cases, too, of strangulated hernia operated on during the same period, a radical cure was included in the procedure, but such are not recorded here, the inquiry being entirely confined to non-strangulated herniae.

As to the risks of the operation for radical cure, if anything is learned from this series it is that the danger is small. Out of the 200 operations there were only three deaths. And when we consider that the procedure is a lengthy one, and that in many cases the conditions for which it was done were very complicated and involved considerable risks, even without operation, the mortality may be said to be low. And this point is further emphasized when we examine the cause of death in the three fatal cases.

As to the risks to the structures of the spermatic cord and testis, only two are recorded. In one I inadvertently snipped across the vas deferens, and in another while separating the sac it was broken across with my finger nail. In another case of a man aged 60, with the largest scrotal hernia I have ever, I think, seen, I designedly removed the testis and remains of the sac, after closing the hernial opening on account of a large hematoma, which formed in the scrotum and subsequently suppurated. The patient had no suppuration in the hernial wound, and made otherwise a perfect recovery, and remained well until his death fifteen or eighteen months later of cerebral apoplexy.

There were no intercurrent troubles except bronchitis, influenza, tonsillitis, cystitis and bad diarrhea, gout and diabetes. But, as mention-

ed, I believe these decidedly influenced the healing of the wounds in some cases. If these cases so affected were eliminated from the series, the latter would show very few cases of suppuration. The ages of the patients ranged from three months to over 70 years; 35 were under 20, 132 between 26 and 60 years of age. Altogether there were 178 patients operated on, six of whom were subjected to a second operation on account of recurrence of the hernia. The vast majority suffered from oblique inguinal hernia—155 out of 197, including 30 on both sides. Excluding the latter there were 86 right and 39 left inguinal. Of femoral herniae there were 10, of umbilical 4, ventral 13.

In almost every other case hard twist Chinese silk boiled in 1 to 20 absolute phenol was used, my earlier experiences with gut of all kinds not impressing me favorably. Some of these silk sutures, as has been said above, worked out to the surface; but, considering that above a thousand must have been used in the 200 operations, the proportion was small.

As to the last question put in regard to the immunity from recurrence after these operations, it is an extremely difficult one to answer. Most of these cases, of course, were hospital patients, and to follow them up has been next to impossible. But this much I can say, namely, that I constantly hear of my patients from various parts of the world in every profession and employment who are quite rid of all their troubles, and that I very rarely now hear of a recurrence. Whether this is due to the fact that Bassini's operation has been the method I cannot say, but I certainly regard it, when carefully carried out, as the best operation of any yet devised.

—The British Medical Journal.

Note.—The above is from the pen of one who was among the pioneers in the operative cure of hernia by the open method. Mr. Barker here gives an ample number of cases to bear testimony to the great value of surgery as a speedy means of radically curing hernia. But he has had a mortality, very small it is true; however, in properly selected cases

there should be none at all in non-strangulated ruptures. Mammoth, old, incarcerated, inguinal or umbilical herniae are not without serious risks in operations.

It is curious to note that Mr. Barker always employs silk suture, the best material without doubt, though the knots left in the tissues quite usually make their way out in time. On the whole the record is most gratifying and encouraging, and warrants the hope of radical cure for the hernial infirmity. T. H. M.

#### VOMITING DURING ANESTHESIA.

In the Medical Times of August 31, 1850, Dr. Snow published a letter in answer to a pamphlet by Professor Libars, entitled "Chloroform, Its Absolute Safe Administration" (Robert Lowe Holmes, 3 and 5 Dunlop street, Glasgow). Referring to the liability of patients to vomit during the administration of chloroform, Dr. Snow wrote: "The patient is indeed liable, though by no means certain, to vomit when the stomach is full, but the vomiting has not in any case been attended with ill consequences of any kind, and I (Snow) have seen at least two hundred patients vomit while partially under the influence of chloroform. In two or three cases, in fact, the patients, who had eaten a very full meal, vomited and inhaled by turn during the whole operation. If the rejected food were liable to enter the glottis of course there would be some inconvenience either at the time or afterward. . . . As regards Professor Libars' apprehension that the great proportion of deaths are due to this cause the simple answer is that the patients who have died from the effects of chloroform did not vomit, and that nothing was found in the windpipe to obstruct respiration in such of them as were examined after death.

—The London Medical Times.

#### CONGENITAL SYPHILIS.

Mr. J. Hutchinson, Jr., believed that congenital syphilis was frequently overlooked in young adult patients, because too great importance was attached to the presence or

absence of the typical malformation of the teeth and of interstitial keratitis. Probably these symptoms were absent in about 50 per cent. of those who had inherited syphilis and who lived to adult age. Our knowledge of the disease of lymphatic glands due to syphilis had in the last few years materially increased. Besides the symmetrical synovitis of the knees, which occurred about the time of the interstitial keratitis, it was certain that a form of osteoarthritis, and of joint disease closely resembling tuberculous arthritis, might develop from inherited syphilis, apart from nodes on the joint ends of the growing long bones. The speaker described cases of apparently gummatous disease of lymphatic glands—cervical, mediastinal, etc., and also of chronic renal disease associated with inherited syphilitic enlargement of the liver and spleen. The hepatic lesions due to this disease might obstruct the inferior vena cava, just as a mediastinal gumma might involve the superior vena cava. Cases of both kinds were related.

—The British Medical Journal.

#### VARICOSE VEINS.

1. While there exists an element of uncertainty as to the etiology and pathology of varicose veins, enough may be ascertained from long-continued observation to confirm certain well-defined views pertaining thereto. For practical purposes, as far as their causation is concerned, varicose veins may be divided into four classes: (1) Congenital cases. These form a large percentage of the cases usually encountered, and they occur in two varieties, those connected with the subcutaneous veins only and those having a direct and gross communication with the deep venous trunks. Heredity plays an important part in this class. (2) Cases due to obstruction of the blood current by external or internal pressure. (3) Cases caused by strain. There is no question that, other things being equal, the veins of young persons subjected to abnormal or sudden strain tend to become varicose more than the veins of those persons not subjected to such strain. Ben-



nett has seen not a few instances of this variety, and suggests that there probably exists some inherent defect in the veins themselves. (4) Cases due to thrombosis. The importance of thrombosis as an etiological factor in varix is not usually dwelt upon. In fact, many instances no doubt occur, in which the formation of a thrombus, prior to the development of varix, has been unnoticed. Examples of this may be found in which, after a severe strain of the leg, primary dilatation of the saphenous vein ensues, following, undoubtedly, thrombosis of the venae comites of the posterior tibial artery. The general disregard of the possibility of thrombosis accounts for the prevailing opinion that varicose veins of the lower extremities are not dangerous to life. Apart from the danger of fatal hemorrhage, the possibility of thrombosis leading to fatal embolism should not be overlooked. This is especially true of varicose veins in the thigh or at the knee, where a recent clot is always a serious and sometimes a fatal complication. There are certain conditions that predispose to thrombosis in varix, such as acute bends or cysts in greatly dilated vessels; situations continually subject to mobility, as at the knee, and traumatism. For certain well-defined reasons, the portion of the inner half of the circumference of the lower limb, from the middle of the thigh to a point three inches below the line of the knee joint, should be regarded as the dangerous region in varix. In this region cysts of great size are common, and huge dilated vessels, valveless and with abrupt bends, are frequent; in this region, too, the veins are especially liable to traumatism, and they are constantly subjected to movements produced by flexion and extension of the joint. Thrombosis may have a beneficial influence as well. If the clot becomes organized spontaneous disappearance of the varix may ensue. The most complete example of spontaneous cure is seen in varicocele, in which occasionally a perfect cure will follow thrombosis, which in such cases is usually of traumatic origin, or in subjects with gouty tendencies.

As regards the palliative treatment of varix the indiscriminate employment of elastic support is strenuously objected to. Massage, discriminately employed, moderate exercise, and elevation of the limb for an hour or so each day, are all that will be required in the early stage. Operative interference is clearly indicated in certain cases, but, as a rule, too often the patient is assured that a cure will be thereby effected. The most that can be achieved by operation is the relief of certain discomforts, the arrest of progress, the prevention of subsequent complications. When the varicose condition is local, that is, with well-defined limits, the isolated dilatations or cysts should undoubtedly be removed. If the disease be confined to the leg operation is sometimes harmful, as it can accomplish no more than moderate elastic support, which might still be necessary. Exception to this rule may be taken when a very tortuous and thin-walled vessel passes obliquely across the shin, where it is especially subject to traumatism. Finally, when the saphena of the thigh is involved no operation should be performed that does not include removal of the vein from a little below the knee, where the two venous trunks form the leg joint, to a point a little above the lowest third of the thigh. Any operation that, under these conditions, limits itself to the leg is useless.

—Lancet, October 15, 1898, No. 3920.

1. Varix: Its Causes and Treatment, with especial Reference to Thrombosis.—William H. Bennett.

#### SOME REMARKS ON THE MIDWIFERY QUESTION—MUST THE MIDWIFE PERISH?

BY THOMAS J. HILLIS, M. D.,  
New York.

The influence of the midwife on the practice of medicine has received a large share of the attention of the profession for the past year. One would hardly think that this unobtrusive old lady would be the cause of such fuss and excitement but such is the fact, and she is now discussed pro and con in and out of medical societies—her individuality, her

methods and her prospects for the future.

From this shaking up it would appear that the great body of the medical fraternity has just awoke to realize that such an individual as she has only begun to exist, or is a thing of rapid pernicious growth. They seem to be unconscious of the fact that she was in existence and past grand mistress of her art in the days of the Pharaohs and long anterior to the lawgiver Moses, but are ready and able to believe that after the passage of a law and the stroke of a Governor's pen she will receive her quietus and cease to exist as a disturbing element in the medical household.

We would have them remember that the customs and usages of a people for ages are not obliterated by the stroke of a Governor's pen or by an act of Congress either. It is easier for a camel to go through the eye of a needle than it is to nullify the unwritten law on the usages of a nation; in fact, it may be said that these old customs and usages are a higher law, and one from which there is seldom any appeal. It is childish to assume that she can be erased and relegated to the shades of some purgatorial limbo for her shortcomings and her memory effaced from the monument she has built for herself in the hearts of the people.

The midwife can be found in every region of the habitable globe, barbarous and civilized alike. She has withstood the mutations of time and fortune for over five thousand years; she will withstand them until time is no more. She was called and appointed to fill an emergency and officiate when bashfulness or expediency demanded her presence, in preference to that of a physician, even though one was in waiting in the anteroom of the accouchement chamber.

Then we shall have to consider this prehistoric figure to-night, as of old, a part and parcel of the social fabric, as to destroy her would be to tear that fabric to pieces and bring about a condition of social chaos.

ABOUT THAT MAGAZINE OF GUN  
COTTON SHE CARRIES CON-  
CEALED IN HER SKIRTS.

A great hubbub is now being made

about the poor equipment and want of qualification of the midwife of to-day, and about the train of disease and disaster that follows in her wake. One thing, however, is certain, that she is an improvement on her sister of the past; though it must be admitted that, like all of us, she has a great deal to learn before she reaches the perfection mark that some would demand as a necessary adjunct of her calling.

Great stress is laid on a few isolated cases adroitly and historically told at the meetings of medical societies from time to time by good men and true, who think they have a mission to perform by opposing her, and who are animated by an honest desire to lay this old lady, the midwife, in the grave of her fathers; as, for instance, a dreadful and tragic event that could have been averted had the female in attendance been an intelligent and qualified person. The truth is simply this: that the exceptional cases told so artfully and well by interested parties only prove the rule, and that rule is, that it is surprising how few fatal cases occur in midwifery practice, when we consider how widespread that practice is. For instance, about half the obstetric work of Greater New York is done by women, most of whom are ordinary midwives, a small fraction of whom are women doctors; the remainder, a goodly portion, is accomplished through the good offices of neighbors and janitresses, which latter often take the place of first assistants to the historic and much-abused midwife.

In the crowded tenement districts and flats this latter contingent, undergraduates of the midwife, take great pleasure in cheating the attending physician out of his fee, by not sending for him until too late, or by obstructing and badgering those interested in his coming. Their obstetric labors over they immediately start in to abuse the physician, whom they intercepted, for his tardiness. After the physician has departed in disgust, often in a huff, the auxiliary and impromptu midwives compare notes and finally compromise with the lying-in woman and other interested ones for a pint of beer, which is drunk with great gusto and many

well wishes for the return of the same.

#### ON THE MORTALITY OF MID-WIFERY PRACTICE.

Not more than 1 or 1-4 per cent. of the great multitude of lying-in women attended by midwives die in the puerperal condition, and it is doubtful if the services of trained physicians would materially alter these figures.

That He tempers the wind to the shorn lamb is a great truth, but not truer than that nature is kind to the puerperal woman in her simple and lowly condition, especially when surrounded by squalor and filth. Even handicapped thus, nature is loath to destroy her creation, and spreads a network of protection, woven with inimitable art, over the exposed surface; this network will prove a bulwark against disease if the seed of contagion has not been already sown by direct contact with the fingers of the attendant, be that attendant doctor, midwife or janitress. No such disasters follow in the train of the midwife as we are told so pathetically, so plaintively, by well-meaning but chicken-hearted gentlemen of our cloth from this and other platforms.

As a rule midwives get frightened early in a case, and often summon a physician when his services are not really required, as the case is a normal one and prognosis most hopeful.

For one stupid and incompetent midwife there are a hundred alert and active ones, who are quick to recognize danger and in time to summon medical aid. Indeed much more injury is done by meddlesome young physicians in pinfeathers, who are attaches, aides-de-camp and supernumeraries of dispensaries and so-called lying-in asylums, with which unfortunately our city is weighed down.

These fledglings often invade a household as the parturient period draws near, and often two or three of them billet themselves on a wretched tenement for periods varying from six hours to four days; sometimes by relays they exceed this mark and sojourn for a week in the poverty-stricken hovel.

This perpetual vigil thus kept up

by the enterprising young medicos in anticipation of a momentary accouchement is sometimes rudely broken, for it often happens that their anticipations are not realized. During this sojourn of the young physicians at the humble hostelry of the parturient women, they make about three hundred vaginal examinations each, and generally succeed in congesting and drying up the parts and causing the woman much pain, often retarding labor for hours and raising the body temperature, thus unfitting her for the ordeal through which she must pass during her lying-in period; indeed, often jeopardizing, if not destroying, her life.

It appears that the objective point in these over frequent examinations is the cervix, and the object to be attained the degree of dilatation of that cervix. A matter, too, of the highest importance to them is, what is the presenting part, and what the position of the head? This latter, though impossible at this early stage, is diagnosed with ease and accuracy by these medical wiseacres.

After dwelling in one of these abodes of misery for two or three days at a stretch, waiting and watching for an event that does not obligingly come off, the young disciples with some disgust pick up their belongings and hie themselves to their respective lodgings. It may be worth while to see what these belongings are. They consist of sometimes a change of clothing in a dressing case and always of an immense gripsack stuffed to bursting with the very latest obstetrical outfit, where it is displayed conspicuously on a front table, that all may see and many wonder and guess of its contents. We will now open the bag thus conspicuously displayed, to find that the young physician provided for himself well in this, his enormous bag, and when he packed it took care to be prepared for all emergencies.

A few of the many things this immense bag contains are a rubber apron, a rubber sheet, a Kelly safety pad, a half-dozen Barnes cervical dilating bags, an ether cone, a chloroform inhaler, a pair of baby scales, a quarter of a dozen perineum nee-

dles, two clamp forceps, two yards of iodoform gauze, one pound of absorbent cotton, a half a dozen two-inch and a quarter dozen three-inch roller bandages, one tongue forceps, a quarter of a dozen scalpels, keen and shining, a symphyseotomy saw, a cephalotribe, a Tarnier forceps, a pair of non-fenestrated bull-dog forceps, a Lusk short forceps, a pelvimeter, and a full set of transfusion instruments. This, as hinted above, is only a small part of the contents of this remarkable bag, lugged into the sick room by this young disciple of Esculapius.

The writer of this article could relate sad reminiscences, reminiscences that would wring the hearts and cause tears to well up in the eyes of strong men, as a result of the meddlesomeness and bungling on the part of those young men playing at medical surgery by the grace and at the pleasure of dispensaries and

lying-in asylums; indeed, very much more than he could of the midwife, though intimately acquainted with her methods for 20 years.

—Medical Record, Oct. 1, '98.

Note.—We cordially indorse every word this thundering Isaias has uttered. Our duty is not to denounce the midwife, but to educate her. She daily ministers to thousands in this country utterly unable to meet physicians' bills, and often serves those in higher ranks of life whose sense of modesty revolts at the thought of indecent exposure before one of the opposite sex. The time has come when every trained nurse should be able in an emergency to attend confinement cases. This branch of the healing art certainly belongs to women. Their very nature and circumstances totally unfit to be general practitioners, but with obstetrics they are certainly at home.

T. H. M.





## Current Medical Literature.

### THE EXTERNAL AND INTERNAL USE OF XEROFORM IN DERMATOLOGY.

BY DR. EHRMANN, Lecturer,  
Vienna.

(Abstracted from the Wiener Medizinischen Blätter, No. 22, 1898.)

The author has used Xeroform in his clinic for more than a year, and believes that he is in a position to pass judgment upon its therapeutic value. He has treated 178 patients with it externally, and 45 patients internally, and since 13 of these latter cases belonged to the first class also, the entire number of cases treated was 210.

The external cases were partly superficial diseases, partly clean incised and operative wounds, and partly suppurations and necroses of the skin.

#### 1. Superficial diseases:

Balanitis .....	41 cases
Moist eczemas .....	30 "
Traumatic erosions of the genitals .....	8 "
Eczema of the anus and nates (13 of them treated internally also) .....	15 "
Iodoform eczemas .....	9 "

#### 2. Suppurations and necroses.

Chancroids .....	47 cases
Varicose ulcers .....	11 "
Tuberculous ulcerations of the nose and penis (1 of each) .....	2 "
Phlegmons of the hand with panaritium .....	5 "
Suppurating buboes .....	11 "
Incised furuncles .....	3 "

#### 3. Clean operative wounds:

Extirpation of dermoid cysts	2 cases
Excision of chancre .....	4 "
Phimosis operations .....	8 "
Excision of mollusca fibrosa.	4 "
Excision of periurethral false passages .....	2 "

Considering Class 3 first, the author states that the wounds were sutured, powdered with Xeroform, and, according to their seat and size, covered either with Xeroform gauze or simple sterilized gauze, and bandaged. Sometimes straps of the 5 per cent. collempastrum saponatum salicylicum were used.

All the operative wounds healed by primary intention; there was no trace of suppuration in the sutures.

As regards the suppurative processes, the author can add to the favorable reports made by others the facts that there never occurred under the Xeroform dressing the granulomatous formations leading to pus retention in the panaritiums and phlegmons of the hands, nor the maceration of the epidermis, and the artificial eczemas that are so common with iodoform. The same was true of the chancroids. When the layer of Xeroform was washed away daily with lukewarm water, and the powder reapplied, cicatrization occurred on the average in two weeks.

In the extensive varicose ulcers the secretion diminished rapidly; a matter of importance for quick cicatrization. The ulcerated surfaces were powdered with Xeroform, and then covered with the 5 per cent. collempastrum saponatum salicylicum; the plaster being renewed twice and the powder once in 24 hours. A more frequent application of the Xeroform is not desirable; too firm a crust is formed, which does not permit the secretion to percolate out.

The same precaution had to be observed with suppurating buboes after incision and with furuncles. The abscess cavities were covered with a thin layer of Xeroform, and then packed with Xeroform or simple

sterilized gauze. In the tuberculous ulcerations this did better than any other dressing; the torpid, flabby granulations became firm, they lost their edematous appearance, and so were prepared for more rapid cicatrization.

Xeroform seemed to do best, however in the widespread inflammatory affections of the skin accompanied with hypersecretion, especially in balanitis. It was better than the salicylic powders in that it has no cauterant action, and yet diminished the secretion, removed the obnoxious odor, and rendered the formation of normal epidermis possible. In erosions of the genitals its advantages were equally marked.

Xeroform was equally beneficial in the moist eczemas when these are circumscribed, as on the hands. This is of especial importance, for in public practice this variety of the disease is very troublesome to the physician. He will welcome a remedy that causes a rapid diminution of the secretion and renders the use of ointments possible. Ehrmann formerly employed a 20 per cent. nitrate of silver solution for that purpose. This was not always agreeable to the patient, who welcomed the substitution of Xeroform.

Among the local eczemas for which Xeroform seemed especially suited were those of the anus and surrounding regions, more especially because its external application as a dusting powder can be combined with its internal administration.

Acting on the suggestion of Hueppe, who employed Xeroform as an intestinal antiseptic in cholera with great advantage, the author administered Xeroform in several dermatoses that are notoriously accompanied with increased decomposition of the intestinal contents.

The obstinacy of anal eczema is due to the fact that its cause is the abnormal composition of the contents of the intestine that pass out. All individuals affected with it have either habitual constipation, or intestinal atony, or suffer from flatulence. From remaining too long in the intestinal canal the feces are ash gray in color, or they have an unusually penetrating smell. Other

cases have alternately constipation and diarrheal stools. In none of these cases can any permanent result be obtained without a suitable treatment of the gastro-intestinal tract. This treatment varies, of course, in every case; regulation of the diet, of the habits of life, of exercise, with abdominal massage, gymnastics, etc., are required, but intestinal disinfection is indicated in all cases. The author formerly employed ichthyol, creosote and menthol for that purpose; but he was glad to replace them by Xeroform, which has no unpleasant odor or taste, and causes no eructations. He administered the drug in doses of 0.5 gram (7 1-2 grains) in wafers, two to four times a day, and he found that it always effected a diminution of the flatulency, greater regularity of the intestinal evacuations, and an improvement in the condition of the feces. He gave thirteen cases of anal eczema Xeroform internally; in two cases only the constipation remained obstinate, though the flatulence diminished. He therefore had recourse to irrigations, abdominal massage and *cascara sagrada*. The anal eczema were cured by the internal and external use of Xeroform.

A second group of dermatoses in which an intestinal antiseptic is of importance are the chronic urticarias and dermatographism.

A certain number of urticaria patients complain spontaneously of constipation, and for them purgatives, administered for a sufficient length of time, are enough. A much larger number, more especially those affected with dermatographism, have normal and satisfactory stools. Yet there is not the least doubt that in these cases also are cases of auto-infection from the intestinal canal, as is proven by the results of treatment.

In some of these cases the usual intestinal antiseptics, salicylate of soda, ichthyol, creosote, menthol, give no results; in two such cases Ehrmann employed Xeroform with success, and now he always commences the treatment with it. Of the 32 cases of urticaria and dermatographism that he has treated during

the past year 23 were cured, 7 were improved and disappeared before treatment was concluded. Two cases that have suffered from urticaria for two and four years respectively, are still under treatment. This is a result that leaves all the other intestinal disinfectants in the shade.

Finally, Ehrmann comes to the conclusion that Xeroform is one of our best and most reliable antiseptics and skin dressings; that its desiccating properties can be used to great advantage in dermatotherapy, and that in anal eczemas and auto-toxic dermatoses it is the best of all the intestinal antiseptics.

#### NORMAL AND ANTIDIPHTE- RIA HORSE SERUM.

Szontagh and Wellman have not been able to prove the presence of nucleo-albumen either in normal or in the curative serum, and they maintain that the curative action cannot therefore be due to nucleo-albumen. The authors next examine the relation of albumen and globulin in these serums. The amount of globulin obtained by saturating serum with magnesic sulphate depends on the temperature. The authors do not look upon it as excluded that there should be a difference in the amount of globulin present in the various serums. The percentage of albumen present is rather less in normal serum than it is in antidiphtheritic serum, but no general conclusions can be drawn from it. The specific gravity of the two serums showed no difference. The lowering of the freezing point is less in antidiphtheritic serum. The electric conductivity is also less in antidiphtheritic serum than in normal serum. This may be due to the increased amount of albumen and the diminished amount of chlorides may not be without influence. The authors then give tables setting out these facts. One table shows the results of the examination of the serum from two horses before and after immunization, and they decidedly confirm the views expressed above. In the serum which the authors obtained from Preisz and Paltauf respectively the lowering of the freezing point and the conduc-

tivity diminished with the increasing amount of antitoxin present. The question of conductivity is not without its practical aspect, as the strength of the curative serum can at least be approximately calculated in this way.

—Deut. med. Woch., July 7, 1898.

#### TWO CASES OF FIBROMYOMA OF THE LARGE INTESTINE.

Riedinger reports two cases of fibromyoma of the large intestine. In addition he refers to the cases reported by Lode Pfannenstiel, Westermarck, Senn and Berg. Of his own cases, one occurred in a woman aged 38 years, who had given birth to six children, the last two and one-half years before. For three weeks she had experienced severe pain in the abdomen resembling labor pains. On examination the abdominal wall was found greatly distended by three tumors. One of these was as large as a fetal head, elastic and hard. Beneath this was a broader tumor, and another of resisting contour. The third tumor was discovered after the distended bladder had been catheterized. A diagnosis was made of penetrating rupture of the uterus and a bony tumor of the pelvis. The woman was, in addition, well advanced in pregnancy. Celiotomy revealed the abdominal cavity distended with fetid gas, and under the abdominal wall lay the buttock of a fetus weighing 3500 grams. The tumors were found attached to the large intestine. The second patient, 24 years old and married, had menstruated regularly since her 18th year, and had given birth to three children, the last ten weeks before. In the eighth month of the last pregnancy a hard swelling was discovered under the diaphragm. Examination made after this labor revealed a tumor twice the size of a man's head, hard and smooth, and mainly in the left half of the abdomen. A diagnosis was made of a solid tumor of the kidney, but celiotomy revealed a fibroid tumor attached to the mesocolon of the splenic flexure and the descending colon.

—The Philadelphia Medical Journal.

### OVARIAN CYSTS AND TYPHOID FEVER.

Lovrich exhibited at the recent meeting of the Royal Hungarian Medical Association a suppurating ovarian tumor. The patient was 24 and had borne two children. Four months before the operation she suffered from an attack of typhoid fever. During convalescence pain in the hypogastrium set in, and abdominal swelling was observed. Accordingly Lovrich operated, removing a cyst of the left ovary. It was full of pus; on cultivation typhoid bacilli were obtained. Widal's reaction was, however, absent, which showed, in Lovrich's opinion, that the suppuration was due to infection from the bacterium coli; that germ reached the ovary through several adherent coils of intestine. The patient made a good recovery.

—Centralbl. f. Gynak., No. 23, 1898.

### BRACHIALGIA AND BRACHIAL NEURALGIA.

Oppenheim (Berl. klin. Woch., June 27, 1898) says that the type of neuralgia is best illustrated by trigeminal neuralgia and by sciatica. The cardinal symptom consists in paroxysmal and severe pain in the course of a nerve and its branches, which may lead to motor, vasomotor and secretory disturbances, but is not associated with symptoms due to structural alteration in the nerve. Some refer all neuralgia to a neuritis, but it must be a very special form which lasts for years and decades without producing symptoms due to degeneration of the nerve. Brachial neuralgia is most often seen in women. Exposure to cold, overuse, and especially traumatism, are put down as causes. Pressure due to tumors, aneurysm, callus, etc., are also assigned as causes. Some authors attribute it to vertebral and spinal cord affections, and others to infections and intoxications. Gowers especially mentions gout. Brachial neuralgia is rarely strictly limited to the course of single nerves, but is more ill-defined, and the tender points are not constant. It has to be distinguished from muscular rheumatism, bone and joint disease, and vertebral and spinal cord affec-

tions. Some would distinguish sharply between brachial neuralgia and neuritis. Speaking from his own experience, Oppenheim thinks that brachial neuralgia is a rare disease, and that it is frequently only a symptom of an organic or functional disease of the central nervous system or of genuine neuritis. He then analyses 189 cases in which there was severe pain in the arm. In 15 there was a spinal lesion, and in 30 marked neuritis. In six cases the neuritis was of an infective or toxic origin. In 12 cases the nature of the infection was doubtful. In 22 cases the etiology consisted in diabetes, gout, alcohol, etc., but there was no evidence of any organic nervous disease. In 14 cases it was an occupation neuralgia. In the chief group of 96 cases, however, it was not really so much a genuine brachial neuralgia as pain occurring in the course of hysteria, neurasthenia, hypochondriasis, etc., or due to a neuropathic or psychopathic diathesis. The pain was not the only symptom, but there was sleeplessness and mental overstrain. Psychic influences were often the starting point of the disease. The effect of treatment accords with this view. The author concludes that genuine brachial neuralgia is rare, and that it most often consists in pain in the arm of ill-defined character and localization, and that it possesses the peculiarities of a pain of psychic or neurasthenic origin, rather than that of a genuine neuralgia.

—The British Medical Journal.

### TREATMENT OF UREMIA.

In a paper entitled "Some Considerations Upon Uremia and Its Treatment," E. W. Mitchell (Cincinnati) agreed with Bouchard that the symptoms of uremia were much like those produced by the poisons that had been extracted from urine; and he thought uremia was often at least due to auto-intoxication from a destruction of tissue, decomposition of foods in the digestive tract, or reabsorption of secretions. The quantity of albumen in the urine was no measure of the danger of the appearance of uremia. In treatment veratrum viride was enulogized. Rest was a



most important factor. Drastic diuretics should not be used. Chloroform destroyed the blood corpuscles if too long used, hence its administration in convulsions should not be prolonged. Morphine might be used once in convulsions in acute cases, but its use in chronic cases or its repeated use in acute cases should be interdicted. Pilocarpin was condemned, as it was likely to drown the patient in his own bronchial secretions. Injections of salt solution might advantageously be used, preceded by venesection if the blood pressure were high.

—British Med. Jour.

#### PLASTIC SURGERY OF CERVIX UTERI.

H. P. Newman (Chicago) presented a communication on the indications for plastic surgery of the cervix uteri, with a new method of operating. He stated that the operation of trachelorrhaphy had been in vogue 25 years, but of late years it had been replaced by amputation of the cervix and modeling of the cervix. Emmet now said that with a few exceptions amputation was the better plan. Newman said he had developed a new method of operating. The indications for amputation were malignant disease, enlargement and hyperplasia of the cervix, conical cervix, incurable laceration, chronic metritis and cervicitis, uterine displacements, congenital elongation and cervical stenosis. Cervical stenosis was the bottom of much pelvic pathology. The technique of the operation was as follows: After the usual preparatory treatment the patient was placed in the Sims or lithotomy position, the cervix drawn down and the uterus curetted. The bullet forceps was then reversed and introduced into the cervix, and traction made from within. The cervix was next transfixed with a knife, and a clean cut made from above downward in the anterior lip. The posterior lip was transfixed and cut in a similar manner, and the plug of intervening tissue removed with curved scissors. If the flaps had been properly made they fell together and covered the portion removed, assum-

ing the appearance of the normal cervix. Sutures were then introduced in four groups, anterior, posterior and lateral. A tampon was introduced and retained for twelve days. The sutures were removed in two weeks. Newman proposed the name of "tracheloplasty" for the operation as a more descriptive name than trachelorrhaphy or amputation of the cervix.

—British Med. Jour.

#### SOME NEGLECTED SIGNS IN CHEST DISEASES.

Norman Bridge (Los Angeles, Cal.) said that in the absence of the more pronounced signs of pulmonary tuberculosis, slight evidences, such as weak inspiration, prolonged or harsh expiration, and a variation in the signs on the two sides must be looked for. He insisted upon making the patient expire profoundly, as rales were often heard then. Deep inspiration and coughing should also be practised. Cracked-pot resonance was a doubtful sign, but when it was on one side only, and accompanied by rales, it meant a lesion. Breath sounds were very likely to be lessened in the early stages of pulmonary tuberculosis, owing to partial closure of the bronchi from deposit about them. Greater cough during recumbency on the affected side was a valuable sign, dependent upon the sinking down into lower bronchi by the action of simple gravity. The comparison of the two sides posteriorly was advised, as in this way one was better able to discover the signs due to the fibrosis that extended around the tuberculous foci and thus to recognize the disease early. Bridge also insisted that fluid in the pleural cavities was often overlooked in children, as dullness was often absent low down, especially on the left side, owing to transmitted resonance from the stomach. The intercostal spaces of children did not bulge, though they were firmer and less compressible than those of adults. Vocal resonance might be distinct, and the only signs that were reliable were the fremitus and the position of the heart.

—British Medical Journal.

## ACUTE MENINGITIS.

Daniel R. Brower (Chicago) laid emphasis on the Skeer sign, which when present would enable a diagnosis of tuberculous meningitis to be made very early. It was dependent on the deposition of tubercles around the pupillary margin of the iris, showing itself first as a distinct wreath of white clouds about a millimetre from the margin. This sign occurred before any change had taken place in the size of the pupillary orifice. After three or four days these minute, cloud-like masses disappeared, and a yellowish-brown circle took their place, becoming more and more attenuated as the pupil dilated. These secondary changes were doubtless due to degeneration of blood vessels and tissues in consequence of tuberculous deposits. Unfortunately the sign was frequently absent, but when present he regarded it as pathognomonic of tuberculous meningitis. He advocated treatment with iodoform by inunction. He preferred a 10 per cent. ointment of iodoform and lanolin applied daily to the shaved scalp. Absorption took place promptly, and iodine might sometimes be discovered in the urine and saliva an hour after this inunction. Of 45 cases treated in this way there were 32 recoveries. H. N. Moyer (Chicago) spoke in indorsement of the efficacy of Brower's treatment.

—British Medical Journal.

## HEADACHES.

H. Grandle (Chicago) read a paper on "Diagnostic Characteristics of Headaches, According to Their Origin, with Especial Reference to Headaches Dependent upon Affections of the Special Senses." He said that not only the peripheral lesion, but also the condition of the nervous system must be considered. Certain peripheral conditions would necessarily cause headache in each case, while, on the other hand, inflammatory affections and mere refractive anomalies led to headaches only in some patients. The difference in the symptoms hinged on the condition of the nervous system. The

most important question concerning the site of a headache was whether it was wholly or predominantly one-sided. One-sided headache was always due to a lesion on the same side of the head, either intracranial or in one of the organs of special sense. The only exception was that form of migraine which, though one-sided at the time, alternated regularly between right and left, for in this case the source was not one-sided, if it were peripheral at all. Conversely, one-sided lesions might in some instances cause headaches not limited to the same side. From the point of view of their time relations, headaches could be classified as: (1) Paroxysms recurring at (a) irregular or (b) regular intervals; (2) attacks following some specific act, and (3) more or less continuous pain. The cases classified under (1) (a) constitute the form called migraine. As to (2)—namely, headaches following specific acts—the most characteristic was the pain brought on by the use of the eyes for near work. The more precise the coincidence of headache with eyework the more probable was the origin in either hypermetropia, hypermetropic astigmatism or myopic astigmatism—in the order mentioned. Headaches more or less persistent, or with irregular intermissions might result from the same optic anomalies, but only in run-down subjects. Other assisting factors could often be demonstrated, such as gastric or intestinal disease, loss of sleep, and particularly insufficient outdoor exercise. Continuous one-sided headaches, if at all connected with the eye, was usually indicative of some serious inflammatory condition, or, in more serious cases, glaucoma. Intense suppurative inflammation of the sinuses led to persistent and usually severe headache. Nasal stenosis, in distinctly neurotic subjects, might cause persistent headache. Inflammatory conditions of the pharyngeal tonsil were sometimes the source of continuous headache in both children and adults. Grandle had seen two instances of persistent, diffuse, one-sided headache, with irregular exacerbations, which could not be traced to any peripheral source except

carious teeth, and which ceased promptly after their extraction.

—British Medical Journal.

#### TEMPORARY CLOSURE OF CAROTID AND SUBCLAVIAN ARTERIES.

G. W. Crile (Cleveland) related a few of the more important results of an experimental research into the effects of temporary closing of the carotid and subclavian arteries. He had made 106 experiments on dogs. A series of operations was undertaken to determine whether the depression of respiration occurring in operations in the region of the brachial plexus was caused by the disturbance of the nerves or the influence of the chloroform. The results indicated that depression followed only when nerves supplying the muscles of respiration were interfered with. Another series of experiments to determine the cause of the profound shock following blows on the lower chest or the abdomen seemed to show that no amount of injury to the solar plexus affected the heart's action and that this had comparatively little influence on respiration. The same was true of blows on the stomach. Blows over the heart itself produced decided fall in blood pressure, varying somewhat in different dogs, and blows over the naked heart caused still greater disturbance. Experiments with foreign bodies in the esophagus showed that those located in the lower end had comparatively little effect, while those located in the upper end cause marked choking and fall in blood pressure, as a result probably of the stimulation of the fibres of the vagus. In regard to foreign bodies in the trachea and larynx, no irritation of the mucosa below the larynx had any influence of importance, but irritation in the larynx produced a fall in blood pressure and embarrassment of respiration. This would suggest that in the removal of foreign bodies from the larynx it would be best to stimulate the heart and to produce local anesthesia of the mucosa by the use of a cocaine spray.

—British Medical Journal.

#### ETHER PNEUMONIA.

J. M. Anders (Philadelphia) said that an analysis of cases occurring in some of the private and public hospitals of Philadelphia showed that ether pneumonia occurred once in about 300 cases. The irregularity, slightness or moderateness of the pyrexia in many cases accounted for the fact that the condition was often overlooked. The micro-organisms giving rise to the pneumonia were probably not usually obtained from the mask or inhaler used, but it was likely that dried secretions were loosened by the moisture in consequence of the increased secretion of the mucosa caused by the irritating effects of the ether, and that they were thus drawn into the lungs. In all the cases that had come under his own observation there was bronchitis, coryza, or some other inflammatory condition of the respiratory tract before the administration of the anesthetic. Any such predisposing causes should, if possible, be removed first. Most cases occurred in cold weather, when perhaps the patient was carried from a warm operating room through cold corridors, and in many cases probably too much ether was administered.

—British Medical Journal.

#### FRACTURE OF THE CLAVICLE IN CHILDREN.

A. E. Gallant (New York) read a paper based on 200 cases treated by Sayre's method, and demonstrated the method of treatment. In a surgical service including 18,042 children aged 10 years and under, there were seen 343 fractures, of which 172 involved the clavicle, especially at the outer portion of its middle third. The shoulder in these cases dropped downward, inward and forward, dragging on the acromial fragment and making an angle at the seat of fracture. The inner fragment had not been found displaced above the outer, as described by Sayre and Gray. A. C. Cotton (Chicago) said that the continued use of plaster might be impracticable because of the irritation to which it gave rise. Sometimes he used a stocking drawn over the arm, which

was then firmly bandaged. R. B. Gilbert (Louisville) in a case corrected the deformity by using a mole-skin perforated bandage. The adjustment of the plaster should be made under chloroform; only partial anesthesia was necessary. Gallant, in reply, emphasized the difficulty of preventing movement, while movement did not always prevent healing. He cited the case of an infant whose clavicle was broken during delivery, but united before the fracture was recognized. He did not use chloroform, but laughing gas, for short operations.

—British Medical Journal.

#### TREATMENT OF RETROVERSION OF UTERUS.

J. Riddle Goffe (New York) read a paper on "Anterior Colpotomy and Shortening of the Round Ligaments Through the Vagina for the Relief of all Cases of Retroversion of the Uterus, Simple or Complicated." Howard Kelly had collected a list of 45 different operations that had been suggested for the relief of uterine posterior displacement. That was a proof of the general interest in the subject. The uterus rested in an unstable position, which varied with the position of the patient. When the body was in the upright position the uterus nominally rested on its anterior surface, and was suspended by the utero-vesical and utero-sacral ligaments, while it was steadied in this position by the broad and round ligaments. It must be concluded, therefore, that the uterus was supported by its ligaments, and was subject to the intra-abdominal pressure. In the normal position this pressure fell upon the posterior surface of the organ, and the fundus was driven still further forward and held in its normal anteverted position. The round and broad ligaments might be relaxed and the uterus would remain in the normal position, but once let the utero-sacral ligaments become stretched and the uterus was sooner or later displaced on account of the forward dropping of the cervix and backward tilting of the fundus. The most frequent cause of relaxation of the utero-sacral ligaments was subinvolution

after parturition. Next in order of frequency came prolapse of the appendages, and then fibroid tumors of the uterus situated near the insertion of the utero-sacral ligaments. Retrodisplacement was not confined to married women. In single women the trouble lay in the vesico-uterine ligaments, and especially in the manner of their insertion into the uterine tissues. They were inserted normally nearer the fundus than the utero-sacral ligaments. In these congenital cases the insertion of the vesico-uterine ligaments was too low on the cervix. This condition might be corrected by detaching the utero-vesical ligaments and attaching them higher up on the anterior surface of the uterus. Next to these ligaments the most rational structures to be utilized in correcting these displacements were the round ligaments. The most popular operation to-day was the modified Alexander operation. The objections to Alexander's operation were several, including hemorrhage, the making of two scars, difficulty in finding the ligaments, and breaking of these structures. Goffe suggested anterior colporrhaphy in all cases of retrodisplacement, whether simple or complicated. The patient was placed in the lithotomy position and a transverse incision made in front of the cervix. The bladder was stripped from the uterus. The anterior vaginal wall was put upon the stretch and divided throughout its extent from the cervix to the internal orifice of the urethra. The finger was then passed over the uterus through this incision, hooked over the cornu, the adhesions were broken up and the fundus brought forward into the vagina and out as far as the vulva. Complete drainage was thus secured from Douglas' pouch down into the vagina. The appendages might also be brought down and removed or treated conservatively. The round ligaments were then drawn and stitched together and the loop stitched to the anterior surface of the uterus near the cervix. The uterus was then returned to its normal position. The bladder was adjusted, the vaginal incision closed by catgut, and a piece of iodoform gauze introduced. He



had treated 31 cases in this way, and in all the cases of simple retroversion (six in number) the results were perfect. Some cases were complicated, requiring resection of the tube and ovary. In a number of these the patients had become pregnant, but had not suffered from a return of the displacement. Attempts at loosening the round ligaments from the connective tissue had been followed by profuse bleeding, in one case requiring hysterectomy.

—British Medical Journal.

#### THE MODERN TREATMENT OF TUBERCULOSIS.

C. Denison (Denver) read a paper entitled "Theory and Conclusions on the Modern Treatment of Tuberculosis." Representing the benefit to patients suffering from tuberculosis as 100 per cent., he said 45 per cent. were affected by climate and changes involving mental influence, exercise and out-of-door life; 30 per cent. were due to good feeding, local supervision and medical treatment; 25 per cent. to inhaling, local medication and antitoxin treatment. So saturating the blood with creosote, for instance, that the bacillus would be stopped in its growth and the patient not be hindered thereby, was, he thought, a mere speculation. He doubted whether inhaled substances ever reached the air vesicles and terminal bronchioles where the disease was located. He would like to demonstrate more clearly than had been done heretofore the fact that (1) correct inhaling, or, more properly, exhaling; (2) altitude above sea level; (3) rightly directed gymnastic training, all worked on the same principle of mechanical distension of the air cells.

—British Med. Jour.

#### THE CURE OF TUBERCULOSIS.

J. Whittaker read a paper on the spontaneous cure of tuberculosis and the imitation of its methods. He stated that two-thirds of humanity at least had tuberculosis, about one-third dying of it, while in the other one-third it became latent or cured. The chief factor in the cure of this third was altitude, which acted by sterilizing, immunizing and invigor-

ating the soil by the action of dryness, cold, sunshine, pure air and increased respiration; but also, and chiefly, by increasing the number of red blood cells, and thereby the oxygenizing power of the blood. He had attempted to imitate the effects of altitude by trying to increase the number of blood corpuscles by the administration of blood. Coagulation could be prevented by obtaining the blood from leech bites, but this was too expensive. Sodium oxalate would prevent coagulation, but was not used from fear of poisoning; therefore, to each quart of blood one-half ounce each of sodium bicarbonate and sugar of milk and one grain of common salt were added. A pint of water containing such a mixture added to a pint of blood being thrown high up into the bowel. Such enemas were retained with ease, and after their repeated use marked increase in weight and gain in nutrition were noticed, especially in anemic cases.

—British Med. Jour.

#### MILK: ITS ABSORPTION VERSUS ITS DIGESTION.

L. D. Bulkley (New York) showed that milk alone was sufficient to meet the needs of the body. Intravenous injection of fresh milk had been safely practiced, showing that the economy could assimilate it without previous digestion and absorption. Working on this theory, Bulkley had adopted the following plan for the rapid absorption of milk without previous curdling and digestion: A number of hours after a meal—usually three or four—the food disappeared from the stomach, with all gastric juice, and the mucous surface became alkaline. This was the "alkaline tide" of the stomach. If at this time milk, free from fat, fresh and alkaline, and at the temperature of the body, were taken, it would excite no secretion of gastric or pancreatic juice on account of its freedom from all irritant qualities, and it would, therefore, pass at once in an unaltered state into the absorbents and system. This saved nature much work and avoided the disturbances of coagulation. The milk entered the blood current more quickly, and in

no way disturbed the appetite for regular meals, even increasing the latter. Milk could thus be taken by patients who could not take it with their meals.

—British Med. Jour.

#### PERICHONDritis OF THE LARYNX.

When the disease is secondary to syphilis, carcinoma or tuberculosis, the diagnosis depends upon a differentiation among these diseases, and is a perichondritis only because it is the cartilage that is involved. The diagnosis between syphilis and carcinoma in doubtful cases is often a most difficult one, as in the case to be reported. As carcinoma is primarily a disease of the soft parts, attacking those in the larynx by preference, the chances of the case being syphilitic are greater when the cartilage is the part involved, especially if a syphilitic history can be obtained.

In a slowly progressing case of perichondritis the diagnosis must necessarily rest between syphilis, carcinoma and tuberculosis. The diagnostic signs of the latter are sufficiently clear, so that it ought not to cause much trouble. In the absence of, or even with, a syphilitic history it may be impossible to decide as to carcinoma, or tubercle, for a syphilitic may suffer from carcinoma or tuberculosis as well as any one else. Many of the symptoms are common to both. The destructive process can be as fatal in cases of syphilis as in those of carcinoma. As to the treatment of this form of perichondritis a few words will suffice. Both carcinomatous and syphilitic perichondritis are always grave. Tracheotomy is to be performed whenever the necessity arises. Laryngotomy, or laryngo-tracheotomy, or any serious intralaryngeal or extralaryngeal operation is hardly to be considered, if there is any extensive perichondrial inflammation. If the case is carcinomatous, it necessarily progresses more or less rapidly to a fatal termination; while, if it is syphilitic, antisyphilitic treatment may hold the process in check, the necrosed tissue may be cast off, or encapsulated, and the individual may live for some time, breathing, if

need be, through a tracheotomy tube or a tracheal opening. In all these cases tracheotomy should be performed as low down as possible.

—By George L. Richards, M. D., of Fall River, Mass., otologist and laryngologist to the Fall River and Emergency Hospitals. The Philadelphia Medical Journal.

#### THE ARGYLL-ROBERTSON PHENOMENON.

Eichhorst draws attention to the fact that this phenomenon, which is usually so constant and lasting, may occasionally be intermittent. Erb has also pointed out that it may vary. In 103 cases of tabes Eichhorst invariably found a permanent loss of the light reflex in all except two women where it was intermittent. (1) A woman, aged 38, with a previous history of syphilis, showed unmistakable signs of tabes in 1893. The unequal pupils reacted to light, but only sluggishly. Three months later there was a total loss of the light reflex. Two years afterwards no further symptoms had developed, and the pupils now again reacted to light, but very sluggishly. The reaction then disappeared for four months, when it again became present for ten days, after which it disappeared. (2) A woman, aged 38, with evidence of syphilis, had been in the clinic on four different occasions. In 1891 the pupils reacted to light, but were sluggish. A month later the pupils reacted very actively to light, and this persisted for two months. In 1895 the patient was readmitted with a perforating ulcer. The left pupil now did not react to light, whereas the right did so sluggishly. In 1897 the left pupil had regained to some extent its power of reacting to light. In both these patients a movable kidney was noted. The author says that the pupil reflex action to light may vary even after a long duration of the disease, and in spite of the patient being otherwise worse.

—Deut. Med. Woch., June 9, 1898.

#### THE TEMPERATURE IN CEREBRAL HEMORRHAGE.

Gilles de la Tourette insists that of all the signs which enable a prognosis or diagnosis to be made when

a comatose patient is seen for the first time, the temperature is by far the most important. (1) In cerebral hemorrhage the temperature may fall at once to 97 degrees or even 95 degrees Fahrenheit, but in three or four hours, or earlier, it rises to 100.4 degrees or 102.2 degrees. If it does not rise beyond 102.2 degrees recovery may be expected, whether it keeps up near that point for twenty-four to thirty-six hours, or tends to fall again at once; but if in the first five or six hours after the stroke the temperature approaches 104 degrees and is rising an hour later, a rapidly fatal issue is almost certain. The rare exceptions are some old or debilitated people, who may die in a few days in spite of the temperature never reaching 102.2 degrees. This applies to the prognosis of all states of coma of intracranial origin, whether due to cerebral hemorrhage or softening, cerebral tumor, the status epilepticus, or fractures of the skull, but the temperature alone is useless for differentiating these conditions. Besides a high temperature the following are of grave prognosis: Early muscular rigidity, extreme persistent myosis, conjugate deviation of the eyes, and acute gluteal decubitus. When any of these are present the prognosis is serious even though the temperature has not passed 102.2 degrees. Though such a useful guide to prognosis the temperature is useless for locating the lesion; with a high temperature it may be equally in the hemispheres—cerebellum, medulla or pons. Temperature does not help the prognosis as to the chance of paralysis if recovery is probable; in the absence of conjugate deviation or early rigidity there are at first no guides, but twenty-four hours later a puffing out of one cheek more than another may indicate that that side will be paralyzed. (2) On the other hand in intoxications the temperature usually falls below normal and the prognosis becomes serious the more it falls. This applies to acute alcoholic or opium poisoning, and to uremic and diabetic coma, a temperature of 95 degrees being not uncommon in the latter. (3) In hysterical coma the temperature remains

normal. Alex. Bruce (*ibid*, July 20, 1898) differs from Gilles de la Tourette in considering the chief value of the thermometer to be in localizing hemorrhages. He bases this belief on a statement of Gowers that in hemorrhage into one of the ventricles there is an initial fall, followed or not by a rise of temperature, while in hemorrhage into the pons there is no initial fall of temperature, which rises from the first.

—Sem. Med., June 8, 1898.

#### UP-TO-DATE DON'TS.

Don't steal another man's good name even if your own is worn out.

Don't raise your hand against your husband—broomhandles are plenty.

Don't pattern after the busy little bee. It's the other fellow that eats the honey.

Don't monopolize one color in your make-up. A ruby nose spoils the effect of ruby lips.

Don't bet with your wife unless you are prepared to lose whether you win or not.

Don't look a gift horse in the mouth. Sell him for what you can get and let the other fellow look.

Don't judge a man by the clothes he wears. Form your opinion from the wearing apparel of his wife.

Don't be a clam. If you must be anything of that kind be a turtle. Then you will have a little snap about you.

Don't take a bull by the horns. Take him by the tail and then you can let go without getting someone to help you.

—The Indian Lancet.

#### THE SEAT OF THE APEX BEAT IN TUBERCULOSIS.

Morano has reinvestigated this subject in the light of Cardile's statement that the apex beat was displaced inward in tuberculosis and early tuberculous disease of the lungs. He examined 150 subjects, divided into three classes: (1) healthy and going about, (2) non-medical cases laid on their back, (3) medical cases confined to bed. In the first two classes the apex beat was in the fourth intercostal space in 67 per cent. and in the fifth in 33 per cent. of the cases. In females the percentage of cases

in which the apex beat is in the fourth space is rather higher. Age tends to lower the position of the apex beat. In about half the cases the apex beat ascended to the fourth space and a little inwards in changing from the erect to the supine position. In the third class of cases the apex beat in tuberculosis of the lungs was in the fourth and fifth spaces six and seven times respectively. Speaking generally the author states that in disease producing obstruction to the lesser circulation the apex beat is lowered. Owing to mistaking the claviculo-costal space for the first intercostal space the fifth intercostal space of many authors is really the fourth. As far as the author's observations have gone with reference to the inward displacement of the apex beat in tubercle they do not confirm those of Cardile.

—*Rif. Med.*, September 3, 1898.

#### WOUND OF THORACIC DUCT.

H. Cushing reports a successful case of suture of the thoracic duct after accidental wound during an operation for the removal of carcinomatous glands in the posterior triangle of the neck, secondary to a former removal of the left breast for scirrhus. In this case the duct was seen as a thin walled, colorless vessel, lying on the scalenus muscle.

A small longitudinal wound was found, and closed by a fine silk passed by a small French needle so as to slightly invert the edges. The patient recovered without further leakage. The thoracic duct is usually free from operative injury, but when it rises in the neck, as in the above case, it is liable to be injured during deep operations in the neck. The author recommends suture in all cases if possible. If this cannot be done he advises a provisional ligature to be placed in the proximal side of the wound, the leakage to be controlled by gauze tampons, and the patient put on low diet. If leakage continues and threatens starvation, the provisional ligature should be tied, with the hope of final readjustment of the collateral circulation, or trusting in the presence of anomalous anastomotic branch which may suffice to carry the lymph into the venous circulation. The results of division or obstruction of the thoracic duct, as shown by experiments on dogs, are fatal from rupture of the receptaculum chyli, causing death either from visceral compression by extravasated fluid or starvation from loss of chyle. The duct may, however, be gradually compressed by tumors without fatal results, the lymph current becoming reversed and taken up by the right lymphatic duct.

—*Annals of Surgery*, June, 1898.

